STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445393	A. BUILDING _____ B. WING _____	03/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT MONTEAGLE (THE)	26 SECOND STREET MONTEAGLE, TN 37356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the annual survey from March 16, 2010, to March 18, 2010, and investigation of complaints #22281, #23879, #25311, #23655, and #24912, no deficiencies were cited for Part 483 Requirements for Long Term Care Facilities for the complaints.	F 000	**Disclaimer:** **Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview the facility failed to accommodate the needs of one resident (#15) of twenty four residents reviewed. The findings included: Medical record review revealed resident #15 was admitted to the facility on October 28, 2003 and readmitted on February 15, 2008 with diagnoses including Osteoporosis, Obstructive Hydrocephalus, Head Injury and Depressive Disorder. Medical record review of the quarterly Minimum Data Set (MDS) dated February 10, 2010, revealed the resident to be total dependent on staff for bed mobility, transfer, eating and dressing. Further review of the MDS revealed resident "responds adequately to simple direct	F 246	**F 246 483.15 (e) (1) REASONABLE ACCOMODATION OF NEEDS PREFERENCES** **A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.** **1. Resident # 15 was immediately given her call light. The care giver was educated regarding call lights being within reach.** **2. All residents in the facility have the potential to be affected.** **3. Assess all residents in the facility to determine resident's ability to access/use call light. SDC/Designee will in-service facility staff on placement of call light to be within reach at all times whether resident is in the bed or the wheel chair. During rounding throughout the day placement of call lights will be checked to ensure is within residents reach. Any call light observed not in reach will be reported to the ADON/Charge nurse of each unit and will be discussed in clinical meeting through out the work week.** **4. DON/Designee will review and discuss call light related issues during department head meeting**	4/23/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carl L Young NHA	Administrator	4-2-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445393	A. BUILDING _____ B. WING _____	03/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT MONTEAGLE (THE)	26 SECOND STREET MONTEAGLE, TN 37356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 1 communication". Observation in the resident's room on March 16, 2010, at 1:00 p.m.; March 17, 2010, at 7:30 a.m., and 8:50 a.m.; and March 18, 2010, at 7:41 a.m., and 8:10 a.m., revealed the resident's call light out of reach. Further observation revealed the resident positioned in reclining wheel chair on one side of room and call light on the bed on opposite side of room. Interview with the Director of Nursing on March 18, 2010, at 8:20 a.m., near the residents room, confirmed that the resident was unable to reach the call light.	F 246	**through out the week. Any issues or concerns will be immediately addressed. Areas identified related to call lights will be brought to the QA meeting monthly.**	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions;	F 272	**F 272 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS** **The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.** **1. Resident #2 was immediately assessed by Nurse Practitioner. Orders were obtained and the soft splint reapplied.** **2. All residents who have splints have the potential to be affected.** **3. SDC/Designee will in-service direct care providers about reporting immediately any open skin areas to their immediate supervisor for notification of MD/NP. It will be placed on the 24 hour report which will be discussed in clinical meeting through out the work week. Any identified open skin areas will be discussed weekly in at risk meeting.** **4. Skin assessments will be performed weekly on residents by a licensed nurse. A performance improvement skin audit will be performed by a**	4/23/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445393	A. BUILDING _____ B. WING _____	03/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT MONTEAGLE (THE)	26 SECOND STREET MONTEAGLE, TN 37356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 2 Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to assess for an open area for one (#2) of twenty-four residents reviewed. The findings included: Resident #2 was admitted to the facility on June 20, 2005, with diagnoses including Diabetes Mellitus, Senile Delusion, Senile Depression, Dementia with Behavior Disturbance, and Alzheimer's disease. Medical record review of the Minimum Data Set (MDS) dated January 28, 2010, revealed the resident had difficulty with long and short term memory and severe difficulty with decision making skills. Continued review of the MDS revealed the resident was non ambulatory, had bilateral contractures of the hands, and required total care for all activities of daily living, including feeding. Review of the Restorative Service Delivery Record for March 2010, revealed an order from Occupational Therapy to Restorative Nursing to apply a left hand splint four to six hours a day,	F 272	licensed nurse weekly and reported in QA monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445393	A. BUILDING _____ B. WING _____	03/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT MONTEAGLE (THE)	26 SECOND STREET MONTEAGLE, TN 37356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 3 due to a previous hand injury. Continued review of the Restorative Service Delivery Record revealed the hand splint had not been applied on March 16, and 17, 2010. Observation on March 16, 2010, at 10:00 a.m., revealed the resident in the bed with the hands contracted, and not wearing a splint on the left hand. Observation on March 18, 2010, at 8:05 a.m., revealed the resident in the wheel chair with the hands contracted and not wearing a splint on the left hand. Observation with Licensed Practical Nurse (LPN#1), on March 18, 2010, at 9:30 a.m., revealed the resident in the bed with the hands contracted and not wearing a splint on the left hand. Continued observation revealed an open area on the resident's left inner thumb. Continued observation revealed the resident was resistant to the LPN opening the hand and moving the fingers. Continued interview with LPN #1, on March 18, 2010, at 9:35 a.m., confirmed the splint had not been applied for the third day and confirmed the resident had an open area to the left thumb which had not been assessed. Interview with the Nurse Practitioner, on March 18, 2010, at 9:45 a.m., in the resident's room confirmed the area had not been brought to his/her attention. Review of the Physician's Progress Notes dated March 18, 2010, revealed: " ...reddened area ...(L) (left) thumb inner aspect (with) small scabbed area to inner aspect of knuckle, open area to inner thumb @ nail base ... (no) exudates, (no) warmth felt, (L) thumb nail with mild yellow discoloration ...Oncychomycosis, Superficial lesion, contraction."	F 272		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445393	A. BUILDING _____ B. WING _____	03/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT MONTEAGLE (THE)	26 SECOND STREET MONTEAGLE, TN 37356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 4 Interview with the Director of Nursing and Licensed Practical Nurse #1, on March 18, 2010, at 12:45 p.m., in the conference room, confirmed the open area had not been assessed.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to develop a care plan addressing weight gain and hand splint use for one (#15) of twenty four residents reviewed. The findings included: Medical record review revealed resident #15 was	F 279	**F 279 483.20(d). 483.20 (k)(1) DEVELOP COMPREHENSIVE CARE PLANS** **A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.** **The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.** **1. Resident #15 plan of care updated to reflect weight gain and hand splint.** **2. All residents have the potential to be affected.** **3. SDC/Designee will in-service licensed staff on use of 24 hr report and updating care plan to reflect residents current condition, change in residents condition, functional ability, adaptive equipment utilization., to include significant weight loss/weight gain and splints. The ADON/designee will review the 24 hr report and review/revise Care plan throughout the work week. Any changes in resident's condition will be discussed in clinical meeting.** **4. The DON/designee will discuss and review care plans weekly at clinical at risk meeting. MDS coordinator will review 25% of care plans monthly to reflect current status. Areas of improvement will be discussed in QA**	4/23/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445393	A. BUILDING _____ B. WING _____	03/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT MONTEAGLE (THE)	26 SECOND STREET MONTEAGLE, TN 37356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 5 admitted to the facility on October 28, 2003 and readmitted on February 15, 2008 with diagnoses including Osteoporosis, Obstructive Hydrocephalus, Head Injury and Depressive Disorder. Record review of the quarterly Minimum Data Set (MDS) dated February 10, 2010, revealed the resident to be total dependent on staff for eating. Further review of the MDS revealed the resident "responds adequately to simple direct communication". Review of the facility monthly weight record revealed the resident's weight for March 2009, at 195.3 pound, and March 2010, at 217.9 pounds (a gain of 22.6 pounds in one year). Review of the comprehensive care plan dated as reviewed January 23, 2010, revealed weight gain was not identified as a problem. Interview with the MDS coordinator on March 18, 2010, in the conference room confirmed the facility failed to identify the gradual weight gain of 22.6 pounds as a problem for the resident, and failed to develop specific individualized approaches for this problem. Continued record review for resident #15 revealed a restorative program ordered. December 31, 2010, for "apply splints to both hands 3-5 hours daily." Observation of the resident on March 16, 17, and 18, 2010, revealed splints were applied to both hands daily. Review of the comprehensive care plan dated as reviewed January 23, 2010, revealed hand splints were not included as an approach for prevention of contractures. Interview with the MDS coordinator on March 18, 2010, in the conference room confirmed the facility failed to identify the hand splints as an	F 279	monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445393	A. BUILDING _____ B. WING _____	03/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT MONTEAGLE (THE)	26 SECOND STREET MONTEAGLE, TN 37356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 6 approach to prevent contractures.	F 279		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to apply a left hand splint for one (#2) of twenty-four residents reviewed. The findings included: Resident #2 was admitted to the facility on June 20, 2005, with diagnoses including Diabetes Mellitus, Senile Delusion, Senile Depression, Dementia with Behavior Disturbance, and Alzheimer's disease. Medical record review of the Minimum Data Set (MDS) dated January 28, 2010, revealed the resident had difficulty with long and short term memory and severe difficulty with decision making skills. Continued review of the MDS revealed the resident was non ambulatory, had bilateral contractures of the hands, and required total care for all activities of daily living, including feeding. Review of the Restorative Service Delivery	F 318	**F 318 483.25 (e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION** **Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.** **1. Resident #2 was immediately assessed by NP. Orders obtained and soft splint re-applied. In-serviced restorative CNA's on change of command with reporting process.** **2. All residents who wear a splint could be potentially affected.** **3. SDC/Designee will in-service direct care staff about reporting process. The restorative aides will report to the Restorative nurse changes in the resident's condition. The restorative nurse/licensed nurse will notify MD/NP with changes in residents condition. It will be placed on the 24 hour report and will be discussed in clinical meeting through- out the work week.** **4. DON/designee will address and discuss residents on restorative caseload weekly in at-risk meeting. The restorative nurse will review and document on residents progress/condition each week. Areas of concerns identified will be discussed each week and QA monthly.**	4/23/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445393	A. BUILDING _____ B. WING _____	03/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT MONTEAGLE (THE)	26 SECOND STREET MONTEAGLE, TN 37356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 7 Record for March 2010, revealed an order from Occupational Therapy to Restorative Nursing to apply a left hand splint four to six hours a day, due to a previous hand injury. Continued review of the Restorative Service Delivery Record revealed the hand splint had not been applied on March 16, and 17, 2010. Observation on March 16, 2010, at 10:00 a.m., revealed the resident in the bed with the hands contracted, and not wearing a splint on the left hand. Observation on March 18, 2010, at 8:05 a.m., revealed the resident in the wheel chair with the hands contracted and not wearing a splint on the left hand. Observation with Licensed Practical Nurse (LPN#1), on March 18, 2010, at 9:30 a.m., revealed the resident in the bed with the hands contracted and not wearing a splint on the left hand. Continued interview with LPN #1, on March 18, 2010, at 9:35 a.m., confirmed the splint had not been applied for the third day. Interview with the Director of Nursing and Licensed Practical Nurse #1, on March 18, 2010, at 12:45 p.m., in the conference room, confirmed the left hand splint had not been applied.	F 318		